Self-Management Goal Setting and the AADE 7

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Objectives

• Implement the AADE 7 behavioral principles in the provision of diabetes self-management education.
• Identify common barriers for:
  • People with diabetes
  • Healthcare providers
  • The healthcare system
• Review the needs of an adult learner.
• Discuss the skills, barriers, and measurement of each AADE 7.
What our patient thinks!

Control my diet, control my life style, control my carbs..... What are you, some kind of freak?

Diabetes Self-Management Education

• A collaborative process for people with or at risk for diabetes.
• Focus on knowledge and skills.
• Results in behavior modification.
• Changes in behavior = self-management.
Diabetes Outcome Standards

• Behavior change is the unique outcome measurement for diabetes self-management education.
• Seven diabetes self-care behavior measures determine effective self-management.
• Diabetes self-care behaviors should be evaluated at baseline and then at regular intervals.
• Measurement of learning, behavioral, clinical, and health status must all be done.
• Individual patient outcomes are to be used to guide the intervention and improve care for that patient.

What is Self-Management?

➢ “The individual’s ability to manage the symptoms, treatment, physical and social consequences, and lifestyle changes inherent in living with a chronic illness.”

➢ Barlow et al. (2002) Patient Education & Counseling 48:177
What is Self-Management Support?

“Making and refining the health care system to FACILITATE patient self-management. This includes patient-provider, patient-health care team, patient-health care system, and the community.”

Glasgow et al, in submission

Patient Education

- Information and skills are taught.
- Usually disease-specific.
- Assumes that knowledge creates behavior change.
- Goal is compliance.
- Health care professionals are the teachers.

Self-Management Support

- Skills to solve pt.-identified problems are taught.
- Skills are generalizable.
- Assumes that confidence yields better outcomes.
- Goal is increased self-efficacy.
- Teachers can be professionals or peers.
Your Role in Diabetes Education

• Help individuals identify barriers.
• Facilitate problem-solving.
• Develop coping skills.
• Results = effective self-care management and behavior change.

Barriers for Persons with Diabetes

• Lack of awareness of:
  • Risk factors for diabetes.
  • Signs and symptoms related to diagnosis.
  • Self-care for prevention of complications.
• Minimal skills for self-management.
• Costs of monitoring equipment & supplies.
• Lack of support for physical activity and nutrition behaviors.
• Long waits for care.
• Fatalism and hopelessness.

Jenkins, C, Todd, E. Diabetes. 1997; 46 (Suppl 2), 37A
Other Personal Barriers

- Individual Health Care System
- Family Education
- Peers Economic
- Culture/Media Transportation
- Spiritual/Religious Community

Jenkins, C, Todd, E. Diabetes. 1997; 46 (Suppl 2), 37A

Barriers for Healthcare Providers

- Time.
- Disorganized records.
- Too little help.
- Not enough resources.
- Reimbursement concerns.
- Office time consumed by acute non-diabetes issues (Episodic Care).
- Pt’s inability to understand/comply w/treatment plan.

Jenkins, C, Todd, E. Diabetes. 1997; 46 (Suppl 2), 37A
Systems Barriers

• Lack of diabetes education programs.

• Few materials for low literacy persons.

• Few materials culturally appropriate.

• Lack of reimbursement for diabetes care and education.

Jenkins, C, Todd, E. Diabetes. 1997; 46 (Suppl 2), 37A

Clinician-Patient Relationship

• HCP is a consultant.

• Encourage open and honest relationship.

• Work within the patient’s limitations.

• Respect for patient who has VETO power.
Common HCP Errors

• Preconceived ideas and set agendas.
• Jumping in to fix a problem.
• Making assumptions.

Adult Learners

• Self-directed.
• Must feel a need to learn.
• Problem-oriented rather than subject oriented.
• Own experiences need to be incorporated (Past and Future).
• Prefer active participation.
• Differ in needs and abilities.
Principles for Adult Education

1. Appeals to multiple senses of sound, sight and touch!
2. Is practical; what must be taught is, what would be nice to know, isn’t!
3. Involves the trainee!
4. Is relatable to past experience!
5. Reduces trainee tensions!

6. Is interesting!
7. Provides opportunity for skill development! Skills are learned by doing, not only watching or listening!
8. Includes repetition to increase retention.
Readiness to Learn Factors

1. Health History/Experience.
2. Current Health Status.
3. Mental Status.
4. Family Members.
5. Stress.
6. Vocation.
7. Finances.

Readiness to Learn Cont’d

9. Educational and Literacy Levels.
10. Previous Knowledge.
11. Physical Factors.
Preparing the Patient

• Health beliefs and myths.
• Provide education.
• Elicit social support.
• Prepare for trial and error.
• Teach problem solving.
• Develop collaborative relationship.

Strategies That Don’t Work

• Urging more willpower
  • “if you would just try harder...”
• Threatening bad outcomes
  • “you’re going to go blind if you don’t do what I tell you to do...”
• The gift of advice
  • “maybe if you joined a nice fitness center...”

Basis of Self-Care
AADE 7 Self-Care Behaviors

- Healthy eating
- Being active
- Monitoring
- Taking medication
- Problem solving
- Healthy coping
- Reducing risks

AADE 7 Healthy Eating

Knowledge
- Effect of food on blood glucose (BG)
- Sources of carbohydrates
- Meal plan (what to eat, when to eat, how much to eat)
- Resources to assist in food choices

Skill
- Meal planning
- Weighing and measuring food
- Carb counting
- Label reading
- Plate Method
Healthy Eating

Potential barriers
- food availability
- family eating patterns, habits
- emotions
- food preferences
- blood glucose control
- knowledge regarding how food affects diabetes control
- Environmental triggers
- Cultural
- Financial

Methods of Measurement
- Patient self-report*
- Observation
- Food and BG records
- 24 hr recall, food frequency questionnaires

Healthy Eating

• Read food labels
• Watch portion sizes
• Limit fast food
• Distribute CHO’s throughout the day
• Watch salt intake (limit 1 teaspoon day)
• Examples of typical breakfast, lunch and dinner.
Teaching Methods – CHO Counting

Serving size
Everything listed on the food label is based on that serving size

1 cup of this food contains 24 grams of carbohydrate

Food Labels Claim

- **Fat Free** – ½ g or less of fat per serving
- **Low Fat** – 3 g or less of fat per serving
- **Sugar Free** – ½ g or less of sugar per serving
- **No Sugar Added** – No sugar added during the processing

- **Calorie Free** – 5 calories or less per serving.
- **Light/Lite** – ½ fewer calories or 50% less than the regular product.
- **Low Sodium/Salt** – 140 mg or less sodium per serving
Avoid SuperSizing

Dietary Tips!

- Handing a person with diabetes a preprinted dietary instruction sheet listing foods, exchanges, choices, etc. is NOT an effective approach meal planning.
- Individualize when possible
- Females: 45-60 grams/meal
- Men: 60-75 grams/meal
- CHO must be distributed throughout the day:
  - 60-60-60-20=200 grams (1600 cal with 50% CHO)
  - 45-45-45-25=160 grams (1600 cal with 40% CHO)

What Do People Drink?

- Water may be sweetened with honey or corn syrup
- Tea - 12 oz. may have up to ¼ cup of sugar
- Hawaiian Punch or kool-aid may have up to ¼ cup sugar
- Juice: may be consumed “ad lib” in hospital, clear liquid diet or at home in general- do not need juice unless BG < 80mg/dL
- No Regular Soda
- Milk is carbohydrate!

Drink Water!

Give “orders” for specific amount!
Put 6-8 cups (or specified amount) in a container and use during day.


AADE 7   Being Active

Knowledge
• Type
• Duration
• Intensity
• Safety precautions, special considerations

Skill
• Develops appropriate activity plan
• Balance with food, medication

Barriers
• Physical limitations
• Time
• Environment
• Fear

Methods of measurement
• Physical limitations
• Patient self-report *
• Observation
• Pedometer
Being Active

- Walk and Talk about Diabetes
- Planned activity in addition to ADL's or work
- 30 minutes on most days of week – may be broken down into 10 – 15 minute increments
- Just move even if in a wheelchair
- Find an “exercise buddy”
- Be specific with “orders” for frequency, duration, intensity, and expected feelings

AADE 7 Monitoring

Knowledge
- Testing schedule
- Target values
- Proper disposal of sharps
- Interpretation, use of results

Skill
- SMBG technique
- Recording BG values
- Equipment use, care

Barriers
- Physical
- Financial
- Cognitive
- Time
- Inconvenient
- Emotional

Methods of Measurement
- Review of log book
- Meter memory/printout
- Self-report
- Demo of technique
Monitoring

- Have clients write down their “numbers”
- Be specific about testing times & when to “call”
- Record keeping – take time to look at patient’s records
- Meter used, technique, frequency, difficulties and insurance?
- Type 2’s may want to decrease testing frequency with rotation of time from day to day to include all meals (include ac and pc)
- Hypoglycemia

AADE 7 Medications

Knowledge
- Name, dose, frequency
- Medication action, side effects
- Action for missed dose
- Action for side effect
- Storage, travel, safety
- Recognition of efficacy

Skill
- Preparation, technique, administration
- Safe handling, disposal
- Dose adjustment
- Recognition, treatment, prevention of low BG

Barriers
- Vision or dexterity
- Financial
- Fear of needles
- Cognitive, math skills
- Embarrassment

Methods of Measurement
- Pill count
- Review of pharmacy refills
- Demonstration
- Self-report*
- BG & medication records
- Observation, role playing
Taking Medications

• Take as prescribed by MD – do not skip doses or only take one if ordered bid to make it last longer
• Take at same time each day
• Keep list of meds in pocketbook and bring to HCP visit
• Rotating Rx’s month to month to cut costs
• Consider combination drugs to reduce costs and number of Rx’s
• Do not take others Rx’s when you run out of a medication or want to lower you BG, i.e.
use neighbors insulin when sugar high because you only take pills.

AADE 7 Problem Solving Especially High and Low Blood Glucose and Sick Days

Knowledge
• Signs, symptoms, causes
• Treatment, guidelines, prevention strategies
• Sick-day rules
• Safety concerns (driving, operating equipment)

Skill
• Hypoglycemia treatment
• Glucagon administration
• Use of BG data to determine actions related to food, exercise, MEDS

Barriers
• Cognitive
• Financial
• Coping strategies
• Emotional
• Physical

Methods of measurement
• Patient self-report
• Review of log book (??)
• Meter memory printout
• Medical chart review
• Frequency of medication adjustment
AADE 7 Reducing Risks of Diabetes Complications

Knowledge
• Standards of care
• Therapeutic goals
• How to decrease risks (through preventive care services)

Skill
• Foot exam
• BP (self)
• SMBG
• Maintaining personal care record

Barriers
• Financial
• Time
• Unaware of disease process or seriousness
• Lacking rapport with provider
• Travel
• Physical disabilities

Methods of Measurement
• Patient self-report
• Chart or exam code audit
• DEMO self-care activities

Reducing Risks
• Hypoglycemia
• Hyperglycemia
• Sick Days
• CVD
• Feet
• Eyes (visual chart vs dilated)
• Kidneys
• Sex
Needle Disposal

- Don’t break off needles
- Place in opaque plastic container such as milk jug or soda bottle
- Fasten cap tightly
- Dispose regular trash not recycle

AADE 7 Healthy Coping

Knowledge
- Recognizing that everyone has problems (not mentioned in core measures)
- Benefits of treatment and self-care
- Motivation is internal function

Skill
- Goal setting
- Problem solving
- Coping strategies
- Self-efficacy

Barriers
- Lack of awareness
- Financial
- Lack of support
- Physical
- Psychosocial distress

Methods of measurement
(recommend validated instruments)
- SF-36/SF-12
- P.A.I.D.
- Zung/Beck Depression Scale
- D-SMART
- Sleeping better at night
- Affect better
Healthy Coping

• Specific self-care skills:
  • Don’t talk, teach behavior.

• Self-management skills: Goal is to develop, practice, and refine strategies for handling situations.

• Coping skills: Goal is to help overcome attitudinal and emotional barriers to acquiring new knowledge and skills.

Develop a Personalized Management Plan

• Identify patient beliefs, fears, resources
• Do risk factor analysis
• Set goals using the AADE 7 Self-Care Behaviors
• Schedule Monitoring/follow up
• Encourage Team Work and Play

Diabetes Education & Program Management, AADE. 2003
Risk Factor Analysis

- Financial cost
- Time commitment
- Other responsibilities or tasks take precedence

When the cost of following a treatment exceeds its perceived benefit, patients will not adhere to the treatment.

Problem-Solving: IDEAL

- Identify the problem.
- Define the problem.
- Explore possible solutions.
- Act on one of the solutions.
- Look back and evaluate.
Identify the Problem

• Health status - development of complications.
• Clinical indicator - A1c, weight, BP, cholesterol.
• Self-care behaviors
  • Knowledge
  • Skill

Define the Problem

• Understand all the conditions and behavior.
• Assess for barriers/obstacles:
  • Knowledge/skill deficits.
  • Competing activities/treatments costs.
  • Forming new habits.
  • Social support, stress, emotions.
Case Study: Mrs. Davis

- Type 2 diabetes
- BMI 30, African American
- Current BP 140/88
- Takes meds correctly – Metformin, Amaryl, Vasotec 5 mg
- Labs: A1C 8.9, Normal Lipids
- No monitor
- No meal plan strategy
- Walking 3 times per week

What are the concerns?

Clinical Concerns

- A1C
- Blood Pressure

Barriers

- No way of self monitoring gluoses
- Knowledge deficit about meal planning strategy.
- Loves to eat high fat diet, obese.
- Stress-works 45 hrs per week, single mom
### Identify Mrs. Davis’s Problem:

<table>
<thead>
<tr>
<th>Self-care behaviors</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy eating</td>
<td>YES</td>
</tr>
<tr>
<td>Being active</td>
<td>NO</td>
</tr>
<tr>
<td>Monitoring</td>
<td>YES</td>
</tr>
<tr>
<td>Taking medication</td>
<td>NO</td>
</tr>
<tr>
<td>Problem solving</td>
<td>??</td>
</tr>
<tr>
<td>Healthy coping</td>
<td>??</td>
</tr>
<tr>
<td>Reducing risks</td>
<td>??</td>
</tr>
</tbody>
</table>

### Self-Care Problem
Healthy Eating and Monitoring

List and prioritize the problems using the following criteria:

- safety concerns
- patient’s agenda
- knowledge about survival skills
- potential for gain
- domino effect
- professional expertise
Mrs. Davis: Exploring for Solutions

- Elicit patient ideas about possible changes.
- Help generate several options.
- Prepare for trial and error.
- Safety priority
- Domino effect
  - Education – record keeping, monitoring, sliding scale, label reading, CHO counting.
  - Return 1-4 weeks with records – activity, insulin doses, food, and qid bg tests

Act on One Solution

- Allow patient to chose strategy.
- “Walk through” a day in which strategy is tried.
- Look for potential obstacles in using the strategy.
- Tailor the strategy to fit the patient’s needs.
- Plan for accountability.
Define the Obstacles

• Knowledge
• Costs
• Habits
• Psycho-social

Mrs Davis/Obstacles:

➢ Competing priorities
➢ Habit patterns

Your Role in Facilitating Change

• Focus on specific behaviors, not outcomes.
• Simplify the regimen.
• Spread behavior change over time – small steps
• Negotiate behavioral goals.
• Customize the plan.
• Give positive reinforcement.
• Elicit family and social support.
• Plan ahead.
Follow-up Visits

• Review agreed upon goals.
• Investigate any new concerns.
• Examine changes in life situation.
• Explore for changes in management goals.
• Solicit patient’s input on problem.
• Begin process of re-defining problems.

Look Back and Evaluate

• Each outcome is an opportunity to learn.
• If one strategy doesn’t work try another one.
• Help patient evaluate the strategy.
• Praise progress.
• Anticipate the BARRIERS
• Expect lapses, failures, and partial successes.
Our Professional Challenge

Because of the complexities and constant care associated with diabetes:
Patients must be thoroughly educated and strategically motivated to self manage their disease.

Summary

- Use the AADE 7 Self-Care behaviors in your assessments.
- Establish a collaborative relationship.
- Help to develop a personal plan.
- Teach problem solving.
- Anticipate the barriers.
- Give positive reinforcement.
Never Give Up!

Change is gradual!!

Our clients need our support!!!